Proceedings

Fourth Annual Business Meeting

National Task Force On Geriatric Blindness

Palmer House, Chicago
May 25-27, 1972

AMERICAN FOUNDATION FOR THE BLIND, INC.

NATIONAL TASK FORCE ON GERIATRIC BLINDNESS

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PROCEEDINGS

FOURTH ANNUAL BUSINESS MEETING
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FOREWORD

This meeting was held as one of the Pre-Forum Sessions of the 99th Annual Forum, National Conference on Social Welfare.

As an annual business meeting of the National Task Force on Geriatric Blindness it provided an opportunity for the American Foundation for the Blind to report and discuss its past and future work on aging and blindness as well as to receive recommendations from the Task Force membership.

The committees and agencies involved with the Foundation in these activities over the past year, participated in the two-day deliberations and submitted the enclosed reports. Discussion and recommendations are incorporated as indicated.

Preliminary committee meetings were convened prior to the annual business meeting. These minutes are included in this report.

I. PRELIMINARY COMMITTEE MEETINGS

Report of Committee on Standards/National Accreditation Council-American Foundation for the Blind

The National Accreditation Council of Agencies Serving Blind Persons had requested the American Foundation for the Blind to review the standards and guidelines in relation to their pertinence for programs for serving aged blind persons. Miss Demby had developed a committee with some Task Force members being invited, and also, including outside experts and consultants who were knowledgeable about the various topics in the standards. Those persons who served on the committee are as follows: Mrs. Louise N. Mumm, Chairman, Nathaniel Brooks, Mrs. Robert Carolan, Mrs. Edwin D. Campbell, Howard H. Hanson, Lowell Iberg, Hobart C. Jackson, Robert Morris, Ollie A. Randall. Miss Marion V. Wurster and Miss Dorothy Demby, Staff, American Foundation for the Blind, and Mrs. Belle Wiggins, Staff, National Accreditation Council, provided consultation and staff service.

Each committee member was asked to choose one or more sections of the service standards which would be reviewed in relation to revising, deleting, adding to them. These remarks were then to be sent in previous to the meeting in Chicago and many committee persons did so; others brought their suggestions and comments to the meeting itself.

The Chairman, Mrs. Louise Mumm, Miss Wurster, Director, Program Development Division and Miss Demby, staff associate of the Task Force, met in New York and planned how the various sections could be reviewed expeditiously. Mrs. Mumm carried out the ideas thus promulgated and the meeting was conducted most efficiently and profitably.

Eight persons attended from the committee, as well as five staff from the Foundation and one from the Task Force. The full committee met on Thursday afternoon, May 25, and in the morning on May 26, and from the suggestions and recommendations, Mrs. Mumm compiled a most complete report, which can be found later on in these Proceedings.

Report of Liaison Committee on Geriatric Blindness - American Foundation for the Blind/American Geriatrics Society

This Committee was convened as part of the annual meeting of the National Task Force on Geriatric Blindness which took place at the Palmer House, Chicago, May 26-27.

Dr. A. L. Kornzweig, Chairman, presided. The attendance included Dr. Wilfred D. David, Dr. Frederick C. Swartz, Dr. David L. Levine, Dr. A. L. Kornzweig; Harold G. Roberts, R. Roy Rusk and Dorothy Demby, Staff.

Major agenda items included (a) a final review and approval of the report of the committee's work in 1972 prepared for presentation at the Task Force Meeting (b) a report and discussion of the Session on Special Concerns, White House Conference on Aging and implementation of Recommendations made (c) materials developed for a Training Program for Clinical Assistants in Low Vision Aid Clinics (d) need for establishment of a Center for Macular Disease at National Eye Institute (e) expansion of Low Vision Aid Clinics with assistance from the American Foundation for the Blind.

Decisions - Agreements - Recommendations:

1. Copies were requested and will be distributed to membership of Dr. Kornzweig's paper on the "Eye in Old Age" as a reprint from "Clinical Geriatrics". Miss Demby will duplicate the reprint for distribution to membership.

2. It was proposed by Dr. David that the National Society for the Prevention of Blindness and the Foundation work together on a strategy to set up a coordinating body in reference to diabetic retinopathy as an urgent need. The ultimate goal would be to involve the National Eye Institute and other sections of National Institute of Health. It was suggested that the American Diabetic Association be involved also.

3. The need for more data banks and the use of existing models was mentioned such as the Model Reporting Areas for Blindness.

4. It was suggested that the urgency of the increase of problems re diabetic retinopathy and macular disease be called to the attention of Dr. Flemming.

5. Federal funds should be sought for development of low

vision aid clinics, possibly in association with the American Foundation for the Blind and the National Society for the Prevention of Blindness.

Summary discussion of items on Agenda:

Report to the Task Force -

Dr. Kornzweig reviewed the report which he had prepared after circulation of a preliminary draft to the membership. The report was accepted as presented. Dr. Kornzweig stated that a copy would be mailed to the American Geriatrics Society in addition to the original - which would become a part of the 1972 Report to the National Task Force on Geriatric Blindness.

Implementation of Recommendations, 1971
Special Concerns Session, W.H.C.A.-

Dr. Kornzweig discussed the recommendations related to the need for a coordinating body to solve problems related to diabetic retinopathy. He pointed out that 50% of elderly blind population are affected by this disease along with other complications. He stated that the National Society for the Prevention of Blindness had addressed themselves to this problem but that further national support is needed. Dr. Swartz discussed the need to educate medical personnel; that the average diabetic does not always get adequate care. It was recognized that there is a need to consider the diabetic in light of his total physical condition. It was also recognized that the National Eye Institute is the logical agency to conduct research on these complications and that there would be stronger support to this as a need if the National Society for the Prevention of Blindness and the American Foundation for the Blind work together on developing a strategy.

The need for educational materials on the eye for those in geriatrics brought out the availability of Dr. Kornzweig's reprint article on the eye.

In discussing medical complications around this eye disease Dr. Kornzweig stated that most diabetics suffer from an occlusive phenomena of the veins. The value of a pilot project on this was mentioned.

A second recommendation from Special Concerns Session was discussed relating to the need to establish a Center for Macular Disease. Dr. Kornzweig explained that this disease is more prevalent after age 65 - causing blindness to the central vision. He also stated that the National Eye Institute has some 18 or 19 related research projects. However, there is a need for more education and research. Dr. Levine alluded to value of data banks for use in such projects. It was recommended that the

urgency and increase be called to the attention of the Federal government via Dr. Flemming, W.H.C.A. Chr.

Low Vision Aid Clinics :

The proposed training curriculum was to have been presented by Dr. Hellinger who was unable to come to Chicago. However, the establishment of more clinics was discussed, recognizing the need for matching federal funds for such a program. Dr. Hoover (also unable to attend) is already working on related issues and perhaps could be useful in coordinating this concern with both committees. It was suggested that Louise Sloan at John Hopkins University should be involved.

Field Trip to Low Vision Aid Clinic, Chicago Lighthouse:

This visit took place on May 26 - 9:30 - 11:30 A. M. Those attending included Dr. Wilfred David, Dr. A. L. Kornzweig, Dr. David Levine, R. Roy Rusk and Dr. Frederick Swartz, and for the Clinic, Mr. McGill, Director, Dr. A.A. Rosenbloom, Optometric Consultant, Mrs. Nancy Fagerstrom, Clinical Assistant Technician.

The Clinic was started in 1954 by a committee of five men, ophthalmologists and optometrists; Dr. Snyder for the ophthalmologists, Dr. Rosenbloom for the optometrists. It was supported by local philanthropic groups. It is close to Cook County Eye & Ear Hospital and the University of Illinois, Eye Clinic. The residents are now getting training in low vision aids. (This should be a requirement for passing American Board Examination.)

Referrals: - 60% - 70% referred by ophthalmologists; 30% have been referred by the Division of Rehabilitation and 10% by eye clinics, Veteran's Administration and word of mouth.

Financial: The charge is $12.00 an hour. The usual first examination takes two hours, follow-up examinations about one hour. No one is rejected. The local Lions Club gives philanthropic support to the needy. The lenses are dispensed at cost plus 20%. Reevaluation at six-month intervals, if necessary, later at yearly intervals.

Diagnosis and need for low vision aids are made by the ophthalmologist. The patient is always referred back to the ophthalmologist or referring optometrist.

What does the patient expect? This is discussed with the

patient by personal contact or by phone. This is important because cases which cannot be helped are screened out. Mobility is important also. An occasional wheel chair patient is accepted.

Clinical Assistant. A good partially sighted individual is usually well motivated. Secretarial experience is very helpful. Her work is divided about as follows: 20% of time on intake and counseling; 20% of time on direct contact with patient on mobility and psychology; 40% of time on paper work and reports; 20% of time on miscellaneous.

Types of Low Vision Aids: (1) Contact lenses. These patients pay more: $37.50 for initial visit; $30.00 for follow-up visits. (2) Telescopic. (3) High plus aids. (4) Magnifying glasses; hand-held and standing. (5) Close circuit television; original cost $3,000.00 now $1,695.00. (6) Talking book machines are supplemental to low vision aids.

Additional Information: The Lighthouse is not a supply house for low vision aids, except for a few simple ones that are dispensed at cost. There is a need for opticians who will supply these aids to the patient on prescription. The doctor-patient relationship is maintained at all times. Over 2000 patients have been seen at the clinic and there is a backlog of about nine months. The clinics are held once a week and occasionally on a Saturday. There is a need for an additional clinic Rehabilitation and counseling is an important aspect of the low vision aid clinic.

Fields of vision are not done now as much as formerly. A copy of the forms used for taking the initial history was also given. The last half hour was used in taking a tour through the rehabilitation and industrial area of the Lighthouse with a guide. Numerous blind people were seen at work on assembly line techniques including drilling, cutting, folding and packaging. Many of these people are employable in private industry, if jobs were available.

It was an instructive and interesting morning, appreciated by all the members of the visiting group.

II. LUNCHEON - PALMER HOUSE, CHICAGO, May 26, 1972

Report of Opening Meeting
National Task Force on Geriatric Blindness
Dr. Arthur S. Flemming, Guest Speaker

The meeting was opened with a welcome to the group in behalf of the American Foundation for the Blind by Harold G. Roberts, the Associate Director for Service. Mr. Garson Meyer chaired the meeting and introduced him as well as the Speaker Dr. Flemming and other guests.

Dr. Arthur S. Flemming, Chr. 1971 White House Conference on Aging and Special Consultant to the President on Aging, as the guest speaker, had consented to receive questions prior to the meeting and responded in an informal way to the following kinds of questions and issues:

1. Potentials for funding involved in use of 75% matching rate for social services under the Social Security Act.-- (Maximum use of adult categories of Social Security Act Titles 1, 10, 14, 16 providing 75% federal reimbursement.) According to James Burr, Office of Aged and Handicapped Community Services Division, any State, through its local Department of Social Services, can develop written agreements with voluntary organizations as affiliates of national organizations, to provide in-home services. The agreement would specify what service would be provided, to whom, cost and under what conditions agreed upon.

The question posed to Dr. Flemming was: "To what extent does this strategy rely upon state department of welfare decisions about what they will use service money for? There is a widespread impression that most state departments have preferred to use almost all of IV-A money for services to children with only a limited amount for all adult categories. To what extent does this represent any real limitation? Further, to what extent is the federal government likely to introduce a closure on this open ended program with the enactment of HRI which would discontinue the open ended character altogether?

2. An alternative approach is represented by a loosening up of Medicaid arrangements. (The same could apply to Medicare.) It is presumably possible by administrative action to waive certain Medicaid procedural requirements so that benefits which are now provided primarily in nursing homes can be made available by waiver to support services outside of nursing homes. This approach does not alter the beneficiary population nor the benefit itself, but only the location for

its delivery. It is our understanding that no such request has yet been made, although the Worcester plan which we have proposed does call for requesting such a waiver through state government. What is the prospect that a national change in policy could be introduced, encouraging such waivering if alternatives to institutions are to be encouraged?

3. A still further approach is the earmarking of funds for experimental programs which shift attention from the institution to non-institutional alternatives. The federal Congress has authorized an extensive program for nutritional services. What is the view that nutritionally oriented services are adequate for the task? What are the prospects for a more general kind of demonstration program which would provide start-up funds for various alternatives?

4. What are the prospects for follow-up action on some kind of the special recommendations which emerged from the Sessions on Special Concerns? We recognize that these are in the package of overall follow-up by federal agencies, but are especially interested in three which were approved by the Special Concerns Session on Aging and Blindness.

   a. The broadening of the Vocational Rehabilitation Act to provide rehabilitation services to the blind without regard to age or economic need (S-1030 and HR-8395 House passed Educational Rehabilitation Bill.) What action is being taken to support this change, and what are its prospects?

   b. What is being done to further direct the attention of the Department of Transportation and HEW to the special mobility requirements of the blind and the handicapped?

5. Various proposals have been made concerning the extension of the Older Americans Act, the responsibilities of the Administration on Aging, and for the establishment of a National Institute on Gerontology or a National Institute on Health Services. What are the prospects that some strengthened federal executive mechanism will be supported which will carry with it control over appropriations and encourage in a financial and personnel sense experimentation in alternative modes for meeting the needs of the disabled and the elderly?

6. What is your reaction to the attached proposed Amendment to Title VII of the Older Americans Act to provide special services to older handicapped persons?

7. What would be your reaction to using general revenues in addition to contributions from employers and employees to make financing of social security cash benefits more adequate?

Dr. Flemming's comments conveyed that he was interested in "parallel services" for older persons; the quality of long term care. He mentioned continued support for Title 3 and Title 7 programs. He spoke of the need for better use of services provided through the Social Security Act and alluded to unused funds that still exist.

The proposed national network of personal care services was acknowledged by Dr. Flemming as a fascinating idea -- one that he would try to implement through government cooperation. He compared it to the food stamp principle. He mentioned the Adult Services as an open ended provision for services under the Social Security Act.

Dr. Flemming reminded the group that better coordination of federal efforts was already being tried. Current concern is on how much is being spent for older adults and use of existing authorities such as HUD.

The new Nutrition Program and the new Project FIND were described as efforts to put emphasis on society. The need for "categories" in government due to the multiple jeopardy of minorities including the special revenues needed for handicapped older persons, was emphasized.

There were many questions from the floor. Dr. Flemming was most open in his responses, admitting his concern and also indicating his hope for a better system of services for older persons in general, and specifically for older blind persons and his stated intent to work toward these ends.

The gist of the questions and responses is as follows:

1. How can one get a handle on the open ended approach? Why is this a problem? "One of the experts on this is Don Simpson in Chicago Regional Office. He has two projects underway. See SRS Commissioners in the HEW Regions. Persistence and initiative are needed."

2. Is there a plan for freezing federal funds? "I haven't heard this."

3. In the interest of prevention, who will initiate recommendations made at WHCA for (a) establishment of a national agency to combat diabetic retinopathy, (b) establishment of National Eye Institute Center for macular disease? "The Office of WHCA expects a response from National Eye

Institute. AFB should also keep after this. Also there is a Post Conference Board serving as a review committee. They will keep on top of all recommendations."

4. Would you comment on the comparability of Title 3 and Title 16 using the categorical approach such as for children in Southeast, for example? "Title 3 still has a 90/10 match. It should be used."

5. How do you account for the Administration's plan to increase social security? There is still the problem of services not getting to those who need it most. "The President has said this is not his last word. Issues on benefits are to be kept open."

6. How soon will Title 3 percentages for federal funding be increased from 75% to 90%. Some communities cannot come up with 25% matching. "It will have to be the next fiscal year."

7. Shouldn't there be a longer time for the projects and also to raise the matching money? Areas of greatest need are suffering the most from this. "When federal government becomes a partner in nutritional programs for example, this should continue for a long time."

III. REPORT TO THE TASK FORCE

Program Development on Aging and Blindness
Miss Dorothy Demby, Staff Associate, NTFOGB

As one of the priority concerns of the Foundation, aging and blindness has continued as program development on the national level and has now extended through the Community Services Division of the American Foundation for the Blind to the regional level. The various reports will give the details on each.

To provide a backdrop against which you may wish to consider our reports, there are two items to review from last year's meeting of the Task Force which took place in April in Los Angeles: (1) the re-focus of program planning at the American Foundation for the Blind. (2) the recommendation which you as a Task Force made to the Foundation.

First item: In reporting on current plans for reshaping the Foundation's service programs, it was announced that the Foundation intended to concentrate its efforts and resources on a limited number of priorities. Major emphasis would be placed on expansion of services and the development of new models for national implementation.

The staff program specialists (such as myself in this role on aging) would be responsible for identification of need, analysis of the problem and the design of new programs to meet needs, while the regional consultants (the field staff) would be responsible for implementation locally. It was also stated that in addition to aging, new priorities would include early child development, career education and independent living to promote improved services.

The second item from last year's meeting was your Recommendation to the Foundation. There were essentially two parts to it:

A. That the Foundation continue involvement in the 1971 White House Conference on Aging.

B. That program development on aging and blindness be extended to the local scene so as to more directly reach older persons.

The White House Conference on Aging activities within the agency have been extensive. Sparked by Task Force members' assistance, the Foundation did succeed in assuming a leadership role in the Conference, not only with the staff serving on technical planning committees for the Conference and as delegates, but more importantly, by having the responsibility to organize, sponsor and conduct a Special Concerns Session on Aging and Blindness at the White House Conference on Aging in December, 1971. You have in your kit of materials the detailed proceedings of that Session which you can review at your leisure. You will be hearing a report from the Chairman of the Planning Committee, Dr. Kornzweig. It is hoped that we might later discuss in depth the five Recommendations made by the Special Concerns Session to determine what further role the Foundation must assume to assure positive results.

Dr. Flemming has described the Conference as an "event in process". The Foundation has continued during this Post-Conference Year of 1972 to be involved in reference to:

A. A Plan of Action to keep older persons in their own homes as opposed to institutions.

B. Advocacy as well as public information.

The Plan of Action as you may know, began in October '71 when 175 national voluntary organization representatives (including Dr. Morris for the American Foundation for the Blind) were called to Washington to approve the Plan and to organize into a National Voluntary Organization Steering Committee. It was intended through their local affiliates that these organizations would help to set up and coordinate advocacy programs for helping older persons remain in their own homes in 300 selected communities.

The Program Development Staff Member assigned to aging at the American Foundation for the Blind has been active with this group since its inception. Much staff time has been devoted to the Steering Committee.

The Committee is currently composed of 137 national voluntary organizations. These organizations participated in the White House Conference on Aging and, on invitation of Dr. Flemming, agreed to participate in a Plan for Action to help older persons remain in or return to their own homes or other places of residence. The program is designed to implement selected policies of the W.H.C.A. and to unite the effort of government and non-governmental organizations to accomplish a specific aim.

There is an Executive Committee of 35 members. The Executive Secretary is David Jeffreys. Officers are Chr. Dr. Ellen Winston, National Council for Homemaker Home Health Aide Service, Inc.; Vice Chr. Peter G. Meek, National Health Council; Secretary Miss

Dorothy Demby, American Foundation for the Blind. Four meetings have been held since October. 310 pilot communities were selected to launch a coordinated program designed to help older persons remain in or return to their own homes or other places of residence. 218 are participating in the program.

The Administration on Aging, in cooperation with the National Center for Voluntary Action, has now made possible full time staff and a secretariat. In the interest of including and serving elderly blind persons within these selected communities, an extensive list of names of local and regional agency staff and citizens active with the Foundation in the field of blindness was submitted. Involvement by staff of Foundation affords one more avenue to extend advocacy on aging and blindness. These communities could be considered by the Foundation for future program development.

Also related to follow-through on the Plan of Action is the American Foundation for the Blind's current effort to organize a coalition of other national voluntary organizations concerned with the handicapped and the aging. Representatives from the National Easter Seal Society for Crippled Children and Adults and the United Cerebral Palsy Association have met individually with this reporter and indicated general interest. Other organizations are being suggested and contacted. It is proposed by one of the organizations contacted that a July meeting be convened. The value of such a group would be the unified approach to considering establishment of a network of personal care organizations as proposed by Dr. Morris and the Max Levinson Gerontological Institute.

Informational and interpretive talks with regional groups and other national agencies about the Conference and its post-year plans have been a part of staff activities. These have extended the opportunity for discussing issues on aging and blindness.

New York State Project:

At last year's meeting, you may recall that a report was made on a New York State Pilot Project on Aging and Blindness sponsored by the Foundation and conducted in five communities by local agencies. Since that time, the pilot project period terminated with an Evaluation Meeting here in New York City. Each of you received the proceedings of that evaluation meeting some time ago in the mail. Attendees included the project team members from all five communities. The moderator for the meeting was Dr. Leslie Fine, member of the Foundation's Liaison Committee and Associate Chief of Psychiatry Services, Geriatric Multi-Services Unit, Coney Island Hospital in Brooklyn. He is not able to be with us today but I am pleased to report that it was generally agreed that the Foundation should extend this effort to other local communities. A professional writer is preparing a publication through the Foundation's Information Department. It is hoped that this project can be used as a prototype in other parts of the country.

One aspect of expanding the Project has already taken place. The Community Service Society of New York is designing and conducting a program using elderly volunteers in institutions through a SERVE Program (Serve and Enrich Retirement by Volunteer Experience). This is a result of the experiment within the Foundation's New York State Project to use visually impaired volunteers which met with enormous success. The Foundation has now funded a small component of the 1972 SERVE Project to keep the program of blind volunteers operative for a limited time. Transportation is the major funding item.

Proposals:

Among the proposals for new programs this year, I would like to mention very briefly the following for your discussion later if time permits.

1. An Eye Care Service for the Multiply-Handicapped Older Adult. The purpose would be to identify physically disabled older adults of low socio-economic levels who are in need of special eye care; to refer them for diagnosis and therapy. Visual defects are reported to occur more frequently among those who have hearing loss, cerebral palsy and among the poor around the country. Case finding, detection and referral is minimal. At least two areas might be selected to set up a service with help of government or private funding for a complete range of services as a model.

2. Informal support has long been given by the Foundation to the establishment of low vision aid clinics. A joint national effort to establish a network of eye care services throughout the country would strengthen current efforts and provide broader use of program planning resources already available.

Upon hearing the remaining reports you will have a fuller idea of our work and progress for this year. However, either of these proposals would focus attention on issues that have not been tackled and that continue to remain on the scene demanding attention. Central to our concerns are those elderly blind persons who are yet unidentified - the ethnic minority, the multiply handicapped - the rich and the poor who have not yet reached the clinic or the agency. One implication here is the need to establish an avenue for dissemination of national program information related to aging and blindness. We see these as challenges for the coming year.

What is this national agency's responsibility? Where do we go from here?

Discussion:

The discussion and questions back and forth pertaining to various aspects of Miss Demby's report elicited the following comments: How can we be sure to keep the impetus on coalition development with other agencies, with keeping the White House Conference on Aging's goals in view and get action this year? Can we tag along with the Administration on Aging profitably? It was indicated that Dr. Flemming had said, "Get to your Regional Commissioners."

Social Security has set up information and referral services and it was suggested that we get in on the top level here, also. The Federal government is developing strategies and then directives to the federal regions for carrying out programs in many ways. Administration on Aging in April, gave training sessions and guidelines were produced in terms of services. The input needs to be now on the national level before it becomes so coalesced that it will not have much of an impact. It was also mentioned that we needed to get in material on blindness as it concerned the nutritional needs and delivery of services here.

Recommendation:

Mr. Fitch recommended that Miss Demby and Task Force members get in touch with personnel of the Administration on Aging and advise them of our concern for elderly blind persons and that they should be considered in all their guidelines; additionally, we will get materials to them to be of help. This was seconded by Dr. Levine and passed.

It was made clear that it should not be specifics but general statements and consultation with us in the future and then in turn we can help them on specifics. There is also the need to dovetail what we say on the national level with the Regional Commissioners, the Foundation's Regional Consultants, and so forth.

Mr. Roberts pointed out it was easier in a way when everything was categorical, rather than more general. For instance, the Office for the Blind and Visually Handicapped now has 1. Dr. Douglas C. MacFarland as Special Assistant to the Administration of the Social and Rehabilitation Service. 2. John D. Twiname has an Advisory Committee on the Needs of Blind Persons and the American Foundation for the Blind's President, John S. Crowley, is on the committee. 3. The Foundation is enlarging its office in Washington, in order to be able to keep track of what other agencies are doing in relation to legislation so that blindness and services can be included.

Other suggestions were related to where the Foundation might make an impact and Mr. Fitch mentioned the emphasis in the United Nations now on aging, as they are planning a session. We should get them on notice concerning blindness in aging persons. Perhaps, the American Foundation for the Blind should get accredited at the United Nations and it was suggested that this be inquired into.

Dr. Kornzweig mentioned that the International Society for Geographical Ophthalmology will be held in Cadiz, Spain. Perhaps, the American Foundation for Overseas Blind would be interested and might sponsor, or participate, or get membership into it.

Committee on Standards - Summary of Recommendations for Programs serving Aging Blind Persons
Mrs. Louise Mumm, Chairman

The charge to the Committee on Standards was to review six sections of the Standards with a view to recommending changes in the Standards to meet the needs of geriatric blind persons.

The Committee consisted of: Lowell Iberg, Hobart C. Jackson, Robert Morris, Howard H. Hanson, Ollie A. Randall, Mrs. Louise N. Mumm, Mrs. Robert Carolan and Mrs. Edwin D. Campbell.

Not all were able to come, but two of those sent in written comments. In addition we had as participative guests William C. Fitch of the Task Force, Harold G. Roberts, R. Roy Rusk and Robert Robinson of the American Foundation for the Blind and Alexander Handel of the National Accreditation Council.

We reviewed six sections. We had a most productive meeting. As you can imagine we wandered from the subject of standards per se to quality of service, which actually enriched our thinking about standards and program.

The following are our recommendations, embracing both specific and general suggestions for review, addition, deletion and change, reflecting our best thinking in the current scene, almost 10 years after the Comstac created its maximum opus.

General Recommendations:

1. Until the Standards can be revised, there are several temporary measures which we recommend.

   a. AFB prepare a monograph for the entire field which might embrace its policy statement in Aging and Visual Impairment, the report of its Special Concerns Session on Aging and Blindness at the 1971 White House Conference on Aging, and the findings of the recent regional workshops on the Aged Blind.

   b. That this monograph or another be made available to NAC to aid in the On-Site Review: Guideline for the Chairman, Assistant Chairman, and Agency Executive (OSR 250-1 Rev 11/71), as a reminder that while questions relating to standards are generic they should be applied with specificity to the aging as well as to other groups.

The following recommendations apply to revision of standards:

1. That certain source sections of the Standards include in the prefatory paragraphs material regarding the aged. For

example

a. Social Services

In the Guiding Principles add a statement that various age groups have specific problems. A paragraph might bring up to date trends in blindness since 1965, calling particular attention to the increasing number of geriatric blind with other health problems, as the life span lengthens.

1) In Social Work, P. 1 again might be more specific about the needs of various age groups with attending physical and emotional problems, mentioning the aging in particular.

2) In Recreation expand P. 3 in introductory section.

3) Regarding Group Residential Care, see later.

b. Orientation and Mobility

The basic assumption should be expanded to include reference to the aged.

c. Rehabilitation Centers

P. 1 of Guiding Principles might refer to visually handicapped of all ages.

2. That the requirements for Personnel be examined and liberalized in each section. The standards are rigid. In recent years there has been an increasing use of "para professionals" or those with less than full professional training, including volunteers, both sighted and blind.

3. That "outreach" be stressed in all sections. This is especially important for the aged. Services to the elderly blind need to tie into the broader delivery system in the community, such as recreation and nutrition. Public agency cooperation needs emphasis. This outreach concept should also be strengthened in Section B, Agency and Community Profile.

4. That families are included in planning, training and executing of problems. This applies to 2-5.1.1, 3.6.2.1, 4.6.2 and is an expansion of the present concept of planning only.

Library Services

Several suggestions related to outreach of library services were made. They would appear more properly under Principles underlying Library Services for the Blind and Visually Handicapped.

Library Services should be provided where there are clusters of elderly blind, notably in nursing homes and recreation centers.

Extension of library service should go to the country.

Library services should include low vision materials.

It is especially important to provide various kinds of library services since some institutions reject talking books.

NAC should recommend to American Library Association that its appropriate unit participate in revising Library Service standards.

Orientation and Mobility Services

A separate section regarding the elderly, comparable to the section on Programs at School and Pre-School Levels for children, should be developed.

The several sections regarding personnel should be reviewed for revision. Experience indicates that a BA degree can be effective, and mobility aides, especially for the elderly in their own homes or institutions can be very useful. An O&M specialist may be used later if necessary.

Rehabilitation Centers

Since rehabilitation can also be given in other than a Center, perhaps the title of this section is a misnomer, even though Item 1 under Group Residential Care for adults gives a good definition of a rehabilitation residence facility.

This section needs to be reviewed and updated, with distinct standards for services, for personnel and for physical facility.

In the Guiding Principles the focus should be on needs of the individual and recognition should be given to the needs of the elderly for whom services can be given in a center or in the community.

A medical and health section should be incorporated with appropriate standards. The need of medical staff to interpret profiles especially for the elderly is important. Low vision aids and prevention should be included too.

The Teacher-client ratio for orientation mobility D.3.3.12 should be removed. Nowhere else are norms cited, and greater flexibility is needed.

Sheltered Workshop

The qualifications for personnel should be reviewed carefully for revision.

The standards should be updated to include the several kinds of activity for the elderly.

Standards need to be developed for work activity centers, and home work activities (home industries) especially as these relate mainly to the elderly.

Social Services

1. While the leading needs of clients which appears in Social Work 2.5, Rehab. Teaching 3.6 and Recreation 4.6 includes "Plans are appropriate for varying age groups -- --", perhaps Purpose 2.2, 3.2 and 4.2 could be rewritten to include needs of the varying age groups, once again calling attention to different needs for different age groups.

2. Social Work

   a. WAC review the feasibility of the amount of comprehensive records required.

   b. 2.5.1.1 Families should be included.

3. Rehabilitation Teaching

   Suggest that the entire section be reworked with the Focus on Service to the client instead of personnel to serve the client. Traditionally this service is primarily for older people. There are many kinds of skills used here - home economics leading. Occupational therapy, etc. and the skills may range from a masters degree to no degree. Both paid staff and volunteers may be engaged in this program. Hence - rework the personnel requirements section.

4. Recreation

   The major revisions here are:

   a. Include a standard calling for transportation service, especially for the elderly, in getting to the agency or community resources.

   b. Recreational centers for the aged blind should be multi-purpose and multi-service.

5. Camping

   a. The National Easter Seal Society for Crippled Children's Revised Guide to Special Camping Programs (1968) in its section called USA Standard Specifications for Making

Buildings and Facilities Accessible and Usable by the Physically Handicapped includes a concern for the aging and particularly includes sight disabilities. Hence it seems more germane than the American Camping Association 1964 standards.

b. Because an agency for the blind may refer clients to camping facilities run by others, or may provide several kinds of camping experiences for the same age group, perhaps two concepts could be added, again general in nature, which would highlight desirable practice. These might be written as:

Selection of a camp

1) The kind of camp selected is related to the individual's potential for profiting from one ratherthan another kind of camp life. (The experts may be able to reword to indicate day camp versus short or long-term camp, camp - solely for the blind or a camp for sighted and blind.)

2) The program the camp offers provides a range of interests and is within the physical and mental capabilities of the potential camper.

The questions could be so phrased as to ascertain whether a sound professional appraisal is made in each such instance. An additional general statement which is particularly applicable to the aged blind might be called Selection of a Camp.

6. Group Residential Care

a. This entire section regarding adults should be rewritten with reference to the Joint Commission on Accreditation of Hospitals Standards.

b. Agencies serving the blind have no institutions for "adults" in general, and serve primarily the elderly. Hence --- the section Group Residential Care for the Elderly. Remove the first kind of facility - rehabilitation center, and place it under Section D3, Rehabilitation Centers.

c. A further standard would be related to multi-purpose and multi-service residence.

7. Financial Assistance

No suggestions were made as the principles stated cover the aged blind adequately.

Vocational Services

Since currently the bulk of the blind are over 65, there should be a high level specialist counselor for the elderly blind.

Out-reach to find appropriate vocational goals for the elderly blind needs to be stressed.

Standards should include the elderly as a volunteer (now remunerative employment) in this section and in C-5.

Discussion:

Mr. Alexander Handel, Executive Director of the National Accreditation Council of Agencies Serving Blind Persons, was asked to respond and fill in some of the information concerning NAC which many Task Force members would not know.

He gave a brief history of the development of Comstac through the efforts of the American Foundation for the Blind and the outcome of the separate agency's work over the last five years. He indicated that the standards were really more than five years old because they were based on ideas several years previous to that, and then the editing and publishing of course took another year. It was time to review, and his Board of Directors asked the National Task Force on Geriatric Blindness to look for the implications for services to persons who were older and blind.

Because the standards had been generically set, they did not reflect programs for special age groups; that is, in relation to specifically setting standards for services to older persons.

Mr. Handel answered questions from various Task Force members and indicated that NAC has approached other groups also to review sections; for instance, the American Library Association, the National Association of Social Workers, the American association of Workers for the Blind in relation to rehabilitation teaching and orientation and mobility. He indicated that NAC would welcome all help and it was also mentioned that there was a need to look at the standards in relation to early child development. He stated that AFB could set up committees if they wanted to look at various sections also.

He was asked if NAC was an operating group, and Mr. Handel told of the number of agencies that had been accredited, the self-study process which goes into it, as well as the help given by regional consultants and other outside experts before the accreditation takes place.

Liaison Committee on Geriatric Blindness
American Foundation for the Blind - American Geriatrics Society
A. L. Kornzweig, M.D., Chairman

The activities of this committee since April 1971's meeting of the Task Force have been directed toward four major objectives.

1. The preparation for and participation in the White House Conference on Aging.

2. Planning a curriculum for paramedical assistants in low vision aid clinics.

3. Further study of screening procedures to find the aged blind and near blind in need of medical and surgical treatment or low vision aids.

4. Further study of methods to implement proposals made at the White House Conference on Aging and at the Session on Special Concerns on Aging and Blindness.

White House Conference on Aging:

The preparation for the White House Conference on Aging was greatly stimulated by the announcement of Dr. Arthur S. Flemming, that Session on Special Concerns would be on the program. Apparently a letter to Dr. Flemming from Mr. M. Robert Barnett and others helped to originate this idea. The American Foundation for the Blind was asked to arrange the program for the session devoted to aging and blindness, to invite the speakers, the participating delegates and other interested persons.

The American Foundation for the Blind gladly accepted this commission since it was so directly connected with its plans and it provided a forum on behalf of aged blind and near blind persons.

An initial meeting to outline such a program was held at the Mt. Sinai Hospital on July 27, 1971. Present at this meeting were Harold G. Roberts, Irvin P. Schloss, Robert Robinson, Miss Dorothy Demby and Dr. A. L. Kornzweig as Chr. of the Planning Committee. Garson Meyer, Dr. Robert Morris, William C. Fitch and Dr. Wilfred D. David, also members of the Committee, offered suggestions prior to the meeting. Plans were initiated at this meeting which eventuated in the final program for the Session on Special Concerns devoted to Aging and Blindness. A copy of the program was included in the full report. The meeting

was well attended by delegates from all over United States, Alaska, Hawaii and Puerto Rico. Representatives of optometrical and ophthalmological societies were present. Delegates from agencies in the field of blindness and in the field of aging participated. Members of the American Geriatrics Society - Gerontological Society were present as well as the National Society for the Prevention of Blindness. There were reporters from several national and local news agencies.

An interesting innovation at this meeting was a group of five elderly persons who were blind and participated in the program as reactors to the proposals presented at the meeting. The speakers covered the subjects of legislation, housing, prevention of blindness, rehabilitation, transportation and independent living at home. The keynote address was made by Senator Jennings Randolph.

Mention must be made of the excellent control of this meeting by its Chairman Garson Meyer, which at times became a bit stormy. Also praise should be given to the recorders, Miss Wurster and Mrs. Farquhar who took the minutes and prepared the final paper.

The paper presented by the Chairman of the Liaison Committee, Dr. A. L. Kornzweig, on "Prevention of Blindness in the Aged", is included in the Special Concerns Session report you have received today. Also included are texts of other papers and the recommendations and proposals passed and accepted by the delegates. These proposals are now incorporated in the final official report of the 1971 White House Conference on Aging.

Low Vision Clinic Assistants:

The task of preparing a curriculum of study for paramedical aids to assist in low vision clinics was assigned to Dr. Eleanor Faye and Dr. George Hellinger. There was some delay in the completion of this project due to the illness of Dr. Faye. The subject presented more difficulties than were at first anticipated. Programs for paramedical aids to ophthalmologists and optometrists were examined, and rejected as being too extensive. Fortunately one person being trained as an aide at the Lighthouse in New York by Dr. Faye has proven to be a practical pilot subject for a low vision aid assistant. Much has been learned from his experiences. Also a taped lecture of Dr. Hellinger on the management of patients from a low vision clinic has been of considerable help in the preparation of a curriculum. Progress has been made and a preliminary curriculum has been devised, - to be included as part of this report later.

Two visits have been made by the members of the committee to Low Vision Aid Clinics at the Lighthouse in New York City and Chicago. We are grateful to Dr. Faye, Mr. Wesley Sprague and

Miss Claire Hood in New York and to Mrs. Nancy Fagerstrom and Dr. A. A. Rosenbloom in Chicago for their invitations and hospitality.

Screening:

Further developments of screening and finding programs have been brought to the attention of the committee. Dr. Leslie Fine mentioned the project being considered by Coney Island Hospital in cooperation with Columbia University. The population of Coney Island Hospital's cachement area has an unusually high number of people over 65 living within it. Incapacitating loss of vision, legal blindness and total blindness are now found preponderantly among the aged. There are many elderly blind people who are not serviced readily and quickly by already existing agencies. The community centered, hospital-based program has had some special value. The proposal for a joint project with Columbia University aims to enlarge and extend this program. The plans have not yet been completed.

Dr. George Hellinger brought to the attention of the committee the development of a mobile unit associated with the Eye Department directed by Dr. Paul Henkind at Montefiore Hospital in the Bronx. It will be manned by the staff of the hospital and low vision aid assistants. Its function will be to explore the southern region of the Bronx in areas of low income with persons on welfare; to find and treat, optically, medically and surgically the visually handicapped and blind aged people who have not been discovered heretofore and therefore are not served by local hospitals and agencies. The project is being supported by the New York State Commission for the Visually Handicapped with the cooperation of the staff and administration at Montefiore Hospital. Dr. Hellinger is the low vision aid consultant.

The committee reviewed and provided comments for a draft copy of a Vision Screening Project Report in South Dakota at the request of Task Force member Howard Hanson.

Implementation of Proposals of the White House Conference on Aging:

Your Chairman spoke with Dr. Robert A. Resnik of the National Eye Institute in Bethesda, Maryland, about the research on diseases of the macula and diabetic retinopathy. There are at present 19 grants in reference to the study of macular disease. To date there is no implementation of the idea of a center for the study of macular disease at the National Eye Institute. Whether this should be fostered and activated by federal authorities, such as Dr. Flemming or Dr. Richardson, or by private

bodies such as the American Foundation for the Blind or the National Society for Prevention of Blindness is a question on which we would like advice from this Task Force.

Dr. Resnik also mentioned that there are 25 grants for research in diabetic retinopathy. The need for intensive and urgent study of this condition is well understood by the medical profession and considerable work is being done at many research centers. There is at present no national coordinating body directing or planning such research. To date the emphasis is on treatment of retinal hemorrhages by several types of photo-coagulation with xenon arc, argon and ruby laser beams. Preventive measures are still limited to proper control of the diabetic condition by diet, insulin and oral antidiabetic drugs. Included in the treatment are drugs to control hypertension and increases in cholesterol and fatty substances in the blood stream. A low fat diet is also advocated, especially unsaturated fats from vegetables and fish. The objective is to prevent or diminish arteriosclerotic formation in the blood vessels.

By way of studies, there are also experimental procedures which attempt to remove large amounts of hemorrhage from the vitreous cavity of the eyeball. The cavity is then filled with sterile clear fluid to enable to eye to see better.

The removal of the pituitary gland by surgery, radiotherapy or radio-active elements such as itrium is still being done in selected cases where the prospects are favorable. However, the post-operative care and the need to replace the hormones which have been sacrificed by the removal of such a major gland have tended to diminish the amount of research in this area.

Dr. Resnik also mentioned that a series of educational pamphlets covering eye diseases are being prepared for general distribution.

At the March 23rd, 1972 meeting Miss Demby presented a brief report on the Foundation's plans and progress to date in carrying out the recommendations and the suggestions of the Task Force and Liaison Committee. Mention was made of the six regional meetings arranged by the American Foundation for the Blind's regional staff, as well as the National Task Force on Independent Living. Mr. J. Albert Asenjo, staff member for this Task Force, discussed the group's purpose and recommendations to the Foundation.

The American Foundation for the Blind's tentative project proposal relating to eye care and the multiply handicapped was also mentioned by Miss Demby and discussed by the members.

Finally the Chairman wishes to thank all the members who have participated diligently and productively in the activities of the Liaison Committee. He is also grateful to the Administrative

Staff of the American Foundation for the Blind, and above all to Miss Dorothy Demby, without whose coordinating ability and inspiring example this report would not have been possible.

Meetings were held on:

1. June 10, 1971 - At the Lighthouse in New York City

2. August 5, 1971, November 4, 1971, January 6, 1972, March 23, 1972 at A.F.B., 15 West 16th Street, New York City

3. May 25, 1972 - In Chicago, at Palmer House

4. May 26, 1972,- Visit to Lighthouse, Low Vision Clinic, Chicago.

Members attending meetings:

Dr. Eleanor E. Faye, Dr. Leslie Fine, Dr. George O. Hellinger, Dr. A. L. Kornzweig, Dr. Peter J. Pinto, and Miss Dorothy Demby, A.F.B. Staff Associate.

Members unable to attend meetings:

Dr. M. Feldstein, Dr. Richard E. Hoover, Dr. Frederick C. Swartz.

Guests at meetings:

1. Miss Ollie A. Randall - Task Force Member

2. Dr. Wilfred D. David - National Society for Prevention of Blindness

3. Mrs. Perry Haber - Consultant, New York City Health Dept.

4. Mr. J. Albert Asenjo - A.F.B. Specialist in Rehabilitation, Staff of Task Force on Independent Living

5. Mr. Wesley Sprague - Executive Director, New York Association for the Blind

6. Miss Claire M. Hood - Lighthouse, Low Vision Clinic

It is recommended that AFB take into consideration the following promising projects:

1. Set up low vision aid clinics.

2. Support assistants in such clinics.

3. Advertise the clinics to the laity.

4. Purchase specialized equipment for these clinics.

5. Set up distribution centers where these instruments could be used by groups and individuals.

Discussion:

The question was raised whether the National Eye Institute's role had any idea of planning for genetic counseling. Dr. David mentioned that testimony on that at the National Eye Institute included retinopathy research -- diabetics in particular. They also were concerned with glaucoma and it looks as though more research is needed. Dr. Swartz mentioned that at one time it was thought you could cut off diabetes just by not reproducing. It is not believed to be so true today, as maybe it is not the pancreas at all which is at fault. Perhaps physicians need to work toward a cure for diabetes and then we won't have to worry as much about genetics and reproduction. Dr. David suggested that there was a need for basic research in diabetic retinopathy and therefore AFB should approach the American Heart Association, the American Kidney Association, American Diabetic Association to join hands with AFB and the National Eye Institute.

Which way do we go then? Dr. Kornzweig suggested that we keep pressing Dr. Flemming and various review committees. Dr. David mentioned that while our priority at the Eye Institute might be on research in diabetic retinopathy, we also should target in on larger groups.

Recommendation:

It was recommended that the National Task Force on Geriatric Blindness (1) send a communication to Dr. Flemming directed toward the National Eye Institute, stating the need for basic research in diabetic retinopathy. The rationale is to get at the cause of diabetes, but also the basic mechanism of it; (2) explore with other national organizations interested in vascular and neurological diseases the possibility of a strong statement on urgency of basic research on diabetes. This should be directed to a high level of government -- Dr. Flemming and/or, Dr. Edward E. David, Jr., Science Advisor to the President with copies to Elliott Richardson, Secretary of HEW and the Committee on Research.

Regional Meetings on Services for Aging Blind Persons

Mrs. Doris P. Sausser, Director, Community Services Division, AFB

Five regional meetings have been held to date. The sixth meeting will be held in San Francisco on June 8 and 9. So all the statistics quoted below will not include any information from the west coast states - AFB's Region VI.

Approximately 5,000 invitations were sent to a very widely representative group of agencies. About 10% of the invitees accepted AFB's invitation to participate in reviewing and seeking solutions to the problems related to geriatric blindness. Part of the value of this wide dissemination of information about the meetings was the interpretation (and public relations, if you will) of AFB's interest in this group of aged blind persons and the enlistment of the interest of other groups of people in helping meet their needs. Attendance was affected in some regions by the federal or state governments setting up meetings after our meetings were announced, but for which attendance was mandatory for persons in the aging field.

The following indicates the wide geographical spread of the meetings, the number of invitees and the attendance by regions:

Regions	Invitations	Responses	Attendance
I-Williamsburg, Va.	966	157	122
II-New Haven, Conn.	1014	17	151
III-St. Charles, Ill.	2507	265	134
IV-Atlanta, Georgia	600	123	100
V-Albuquerque, N.M.	325	99	81
	5412	661	588

Participation by Members of the National Task Force:

The regional consultants involved many Task Force members in planning for the meetings, and as participants. The Task Force members in turn were very helpful and supportive of all the work going into planning and conducting the meetings. In fact, it would be fair to say "we couldn't have done it without you". It was especially helpful to have your knowledge and expertise in all phases of the development of the regional meetings. It is interesting to note how much you all contributed toward the success of the five meetings.

Region I	Dr. Robert Morris - Banquet Speaker Lowell Iberg - Planning Committee member Group Discussion Leader Chairman at Banquet
Region II	Garson Meyer - Luncheon speaker David Jeffreys - Planning Committee member Group Discussion Leader Luncheon Chairman
Region III	William Fitch - Luncheon speaker
Region IV	Miss Ollie Randall - Keynote speaker Group Discussion Leader Dr. David Levine - Planning Committee member Group Discussion Leader
Region V	Howard Hanson - Planning Committee member Group Discussion Leader

Mrs. Russell will be the Chairman of the Region VI luncheon.

Dr. Flemming was a major speaker at the Williamsburg and Albuquerque meetings and he seemed very interested in the meetings, and said several times that AFB was one of the first national agencies to follow up so actively on the White House Conference on Aging - and especially to take our concerns to the regional and local levels.

Agency and Professional Representation:

It is interesting to note that about 50% of the agencies represented were outside of our specialized field; thus indicating their interest and as many said, "interest in learning more about blindness and how to work with blind people". The one exception to the above is Region V where about two-thirds of the agencies represented were from our specialized field. It must be remembered though that this region on the whole has few voluntary agencies, and the geographical distances are very great.

The following summarizes attendance by specialized and non-specialized agencies:

Region I -	Specialized	66	Total Agencies	132
	Non -Specialized	66		
Region II	Specialized	67	Total Agencies	124
	Non Specialized	57		
Region III	Specialized	66	Total Agencies	134
	Non Specialized	68		

Region IV	Specialized	53	Total Agencies	100
	Non-Specialized	47		
Region V	Specialized	36	Total Agencies	55
	Non-Specialized	19		

In order for you to have some idea of the broad scope of the representativeness of these non-specialized agencies, a sample of the categories of agencies is listed. This list is not all inclusive, of course.

Community Action
Government (many areas such as V.A., etc.)
Library Services
Generic Rehabilitation Center
Organizations of Retired Persons
Services for the Aging
Economic Opportunity Council
Community Health Agencies
Nursing Homes
Commission on Aging
Office of Aging
Elderly Affairs
Department of Recreation
Model Cities
Community Chest and Planning
Public Welfare
Health, Education and Welfare
Gerontology Education
Hospitals
Senior Citizens
Occupational Therapy
Lions Clubs

Consumers of services were also invited to attend the regional meetings. However, the regional consultants were very limited in meeting the expenses of the consumers because of the budget allowances; and since most consumers were living in an economically deprived situation their expenses had to be met. It would have been fruitful for the group discussions if more consumers could have attended for they, without exception, added to the deliberations. In some instances, the consumers were used as such for their point of view as recipients of service. In other regions they were asked to act as resource people or consultants. In Region IV, consumers demonstrated techniques of training in mobility and in home management skills during the "how to" teaching sessions.

Number of States Represented:

A total of 38 states and the Commonwealth of Puerto Rico were represented in the five regional meetings. Only three states and the Virgin Islands had no representation.

Preference for Discussion Groups or Areas of Interest:

This is difficult to summarize as each regional planning committee selected a different group discussion "umbrella" (or title) for their discussion groups although on the whole, content within the discussion groups centered around much of the same sub-topics. In four regions invitees were asked to indicate their preference for subject areas, and the following lists the responses which in turn reflects areas of concern. Region V Planning Committee decided arbitrarily to assign participants to groups, based on known factors. It is interesting to note, in view of national emphases, the seeming lack of interest in transportation and the next was home health care. In some instances although assignments were made to these groups, attendees just didn't follow their assignments.

Region I	Community Participation	37
	Volunteers	26
	Rehabilitation Services	22
	Home	21
	Recreation	16
	Nursing Home	10
Region II	Employment	13
	Full Social Participation	23
	Home Health Care	15
	Personal Adjustment	22
	Prevention of Blindness	15
	Social & Mental Health	22
	Transportation	10
	Volunteers	16
Region III	Independent Living at Home	26
	Independent Living in Community	17
	Physical & Mental Health	26
	Retirement Roles & Activities	24
Region IV	Increased Social Participation	66
	Rehabilitation - Personal and Economic	56
	Health Care	46
	Transportation	32

These figures cannot be compared to actual attendance for many indicated a first and second priority choice so there is some duplication in the numbers. First choices were assigned whenever possible but every effort was made to keep groups uniform in size.

Evaluation of Meetings:

From comments received during the five meetings, and the evaluations by the regional consultants, it seemed that the

participants were appreciative of the opportunity to get together and to discuss common problems. On the whole, content as provided by discussion leaders was considered to be excellent. It seemed at one point that too much was attempting to be covered within the time limits, but no major problems arose. However, there could have been more in-depth discussion if the topic assignments had been more limited. This led to several people commenting that these series of meetings should be considered as "first" regional meetings on services to aging blind persons.

Many people in the aging field said they didn't know AFB was interested in the aging. Their "exposure at least enhanced their attitudes toward blind persons".

The budget was a problem for the Planning Committees and the regional consultants, resulting in inequities in emoluments. As one regional consultant said, "I had to beg, borrow, and plead with people to get them .....(to provide leadership).... and to pay their own way while they were doing it". Another, "Bargaining tactics were used with program people that ordinarily would not have been used".

It is the consensus of staff that the goals of the regional meetings on services for aging blind persons were accomplished. The goals were comparable to those set by the National Task Force on Geriatric Blindness; i.e. to promote the general welfare of aged blind persons through involvement of the total community in concern for elderly people who happen to be blind.

Many Planning Committee members and the regional consultants strongly suggest that the regional committees meet again to evaluate this experience after the proceedings are available, and to develop proposals for next steps which in turn can then be presented to the National Task Force on Geriatric Blindness. For example, one of the Region V Planning Committee members who is also the Assistant Regional Representative for Aging Services has proposed to the regional consultant and other AFB staff that a jointly funded project be developed; and that this and similar matters be considered at a meeting of the Regional Planning Committee.

Recommendations:

Unfortunately,none of the proceedings have been completed, so there are few recommendations to report at this time. Each regional meeting was opened with a statement of purposes which included that the discussion groups recommend future activites, projects, etc. which could be implemented on the local level. At this point, and until the final proceedings are available, it would seem we have not been too successful in obtaining concrete suggestions or recommendations for activities to be

implemented. Perhaps this is tied in with the suggestion for an additional regional meeting in which to explore further ideas, to share information and plans, and on this basis then, to collaborate more dynamically on the use of community resources.

The regional consultants were asked to submit recommendations from the minutes of discussion groups which they had already received, recognizing that many reports had not been submitted, and the following list was compiled. It is, of course, incomplete and unedited at this time.

1. Consider the obvious success of the practical demonstrations offered in this meeting (Region IV) as a clue to the Information Department's Public Education Division that these approaches are significant in modifying attitudes about blind persons.

2. Review the age limit for Social Security benefits to see whether lowering the age to 60 might be indicated, recognizing that such an action might encourage employers to retire workers earlier - an undesirable consequence.

3. To support actions to include personal adjustment services to older blind persons in vocational rehabilitation programs, since most older blind persons need specific assistance to achieve a satisfactory adjustment.

4. Work toward a more unified service delivery system within agencies serving blind persons and encourage trained staff to function as coordinators and consultants to community resources in order to expand and enrich service programs.

5. Utilize short-term group evaluation and training programs to get older blind persons temporarily out of their homes and into healthier living environments to improve personal adjustment training.

6. Place emphasis on involving blind and sighted members of communities in volunteer service programs for the blind.

7. Remove the ceiling limitation on earnings of Social Security recipients.

8. Endorse the passage of legislation for rehabilitation of elderly blind persons.

9. Exempt older persons from minimum wage regulations for elderly blind homebound workers.

10. Educate older blind persons in eye care, prevention of blindness and how to live with little or no vision.

11. Educate staff and volunteers in understanding the older blind person, so that the extent of quality of help provided can meet the needs of the particular individual.

12. Involve blind persons in the planning and implementation of their own activities.

13. Involve blind persons in actually making some contribution in the way of skills and in educating other aged blind.

14. Consider nutrition as a facet of home health care as an indispensable component of all services related to the elderly.

15. Support Federal legislation to provide financial assistance for nutritional services to the aged.

16. Do not overlook, during the thrust of developing services, the need to provide service on an individual basis.

17. Establish a home vision screening for elderly blind.

18. Provide comprehensive health care programs to elderly in their community.

19. Seek Federal grants to provide transportation projects for elderly on a state level.

20. Provide more training and funding for rehabilitation of aged visually impaired and blind individuals through the resources of rehabilitation services.

21. Assure ourselves the State units on aging are fully aware of the needs of this group of elderly, i.e. by arranging for meetings with appropriate agencies and persons serving the blind or older persons and identifying the population of elderly blind persons in the State.

22. Work continually with appropriate state and federal legislative representatives to assure that in any national health plan there is adequate recognition and services available to elderly visually impaired and blind persons.

23. Develop adequate community service training and home support to maintain the visually impaired and blind older persons in their homes.

24. Collaborate and coordinate efforts with community agencies having services for the visually impaired and blind elderly to avoid duplication services wherever possible.

When proceedings of the regional meetings on Services for Aging Blind Persons are completed, copies will be made available to the National Task Force on Geriatric Blindness. Out of these proceedings it is hoped that the Information Department of the American Foundation for the Blind will be able to produce a pamphlet of selected papers, or at least to have one issue of the New OUTLOOK devoted to papers presented during the meetings.

The members of the National Task Force on Geriatric Blindness should take credit for planting the seeds and being the generators of all these efforts to assist aging "blind people become just people".

Discussion:

In discussing the implications of Mrs. Sausser's Report, Dr. David mentioned that he thought one of the strengths of it was that they included consumers of services who told in simple ways about their difficulties with services or the lack of them until it was too late. Dr. Levine saw the need for follow-up and wondered if it could be done through universities. Other members of the Task Force who had participated in the meetings also felt that these should not be discontinued this year.

Mr. Iberg suggested that the Workshops be continued next year and they they continue to use consumers, ophthalmologists, and optometrists in the participation and build in minority components. It was pointed out that, rather than working on a regional level, the Planning Committee might localize its efforts or get it on a state level rather than regional.

Recommendation:

Mrs. Russell recommended that state units on aging will be required to have training sessions and recommended that AFB cooperate with them to get blindness as a topic or materials on the program and exploit that source of funding. This was approved.

Mr. Hanson felt that the present planning committees should get together to evaluate the past sessions and go on to planning on the state and local levels. Mr. Roberts responded that we would not be able to do it in all states. It has been good to use these meetings as a vehicle for getting information to persons, but that the next sessions should aim toward the delivery of services such as was done in the New York State Project. He stressed that program development needed to be more than information giving and discussions, and the regional planning

groups should see that all the funding potentials are used and involve the Regional Commissioners on aging in each area.

Mr. Robinson added that it would be good to tie into existing mechanisms and engage the aging and blindness agencies such as was done in New York State. Miss Demby added that now that the National Center for Voluntary Action had designated some 300-odd communities where there would be concentration on aging persons, the regional consultants might look at these in their region and see whether they could find a way to use these existing programs advantageously. Mr. Fitch felt that there needed to be some give-away materials, maybe based on regional meetings, and this will be explored by Mrs. Sausser in the future.

There was concern expressed in every regional meeting that the recommendations and ideas would get back to the National Task Force on Geriatric Blindness, which of course, it has; equally, there was concern for action back in the region.

New Aspects of AFB Program Development
Miss Marion V. Wurster, Director, Program Development Div.

Miss Wurster gave a brief report on other priority efforts at AFB to develop program and services for blind persons. These included the newly appointed task forces on Early Child Development, Independent Living, Career Education.

Each was described and some of their recommendations and foci were discussed.

In addition, Miss Wurster reported on the cooperative projects of AFB and the Sex Information and Educational Council of the United States which is preparing a guideline on sex education for the visually handicapped, to be field tested; the National Committee on Children and Youth, which will continue to meet, but more specifically, the workshop given in Atlanta recently to train workers with children and youth agencies on helping blind boys and girls be part of their regular program.

General Discussion:

Other topics were brought up by the Task Force members for consideration. Mr. Fitch suggested that there be a representation of AFB's interests on each National Advisory Board, such as the Older Americans' Advisory Conference, the Post-Conference Planning Board, and so forth. He recommended that AFB also send a letter, expressing its interests in various groups such as, the Senate's Special Committee on Aging for a small special interest committee. This letter should go to Senator Church and other interested persons. Mr. McNamara added that new avenues might be opened up by representation on the Health Insurance Benefits Advisory Council.

Recommendation:

To recapitulate all these ideas, it was recommended that AFB study the desirability of getting representation on Advisory Councils and committees of all sorts. This was agreed to and Mr. Schloss, in our Washington Office, will be consulted on ideas of which committees to approach.

Dr. Levine also brought up the question of getting blindness considered in various curricula such as, education, social work, and so forth, and that AFB study new patterns and keep trying to get information into curricula. Mrs. Russell mentioned that the Administration on Aging, when setting up their gerontological curricula should be informed that blindness be included. Mr. Robinson said that he has been talking with schools of social work for input on research into blindness. Mr. McNamara suggested that AFB approach other national organizations such as the National Education Association, and so forth, with the

intent of getting blindness and materials into the hands of many types of professional workers.

Mr. Howard Hanson, the South Dakota State Director of Service to the Visually Impaired, had brought a one-sheet resume * of vision screening of nursing homes in South Dakota: Project of Title III, the Older Americans Act. In the discussion which followed, it was suggested that there was a great gap between availability and utilization of services and there was need for research on why. Mr. Hanson mentioned that the Portland and New York studies agree with the findings in this one --namely, that many people did not seek help with their vision before it was too late. Mr. Jackson stated that studies of blind communities show there is a 50% gap and even more between the eligibility and the using and wondered if we could focus on this.

Mr. Fitch mentioned that we needed to let Dr. Flemming and the FIND staff know some of the problems and see if the blindness factor could be worked into the nutrition Project. There needs to be a multifaceted screening process. Mr. Jeffreys felt that the National Center for Voluntary Action was very active with Dr. Flemming and other agencies. They are aware that malnutrition is not the only thing, but can only zero in on that now, but other facets will be looked at later. Mr. McNamara said that he would be willing to introduce some of the recommendations of this Task Force to the American Association of Retired Persons and the National Council on Senior Centers.

Dr. Morris moved that we support the National Institute of Gerontology to conduct continuous research and locate data which will give the basis for future action programs. This was approved.

Mr. Fitch mentioned that older blind persons are especially exploited and that the Task Force members needed to get to consumer groups and alert them to what was happening. The Consumer Federation of America is an umbrella organization mainly with credit unions, consumer groups, labor organizations, American Association of Retired Persons, National Association of Senior Centers, the National Council on Aging, being part of it.

Recommendation:

It was recommended that AFB get in this Consumer Federation as a member, and in that way could also get representation on the program. This was approved and discussion turned to how the Task Force members could be an extension of AFB's staff in representing its interests on various national committees and councils.

* Appendix

It was suggested that Miss Demby send a form to all Task Force members in order to get the list updated of what organizations each Task Force member belonged to and where they thought they might be able to speak for AFB as well as for their own organization and interest. This will be done sometime in the near future.

Mr. Hanson also brought up concerns about the Model Reporting Area on Blindness. The State Directors of the Blind are very upset as the National Eye Institute is not going to continue doing it. The State Directors passed a resolution urging National Eye Institute or some other agency to reestablish and continue it.

Mr. Roberts mentioned that National Eye Institute wanted to get it out of their house, so to speak, and had asked the American Foundation for the Blind and the National Society for the Prevention of Blindness to consider taking it on contract. Dr. David cited that there are problems with it and the two organizations have looked at the program. Many states have been losing staff and have not been carrying on very much anyway. The committee was considering continuing it, but adding psycho-social and other items. Consideration has been given to two ways of continuing and one would be to continue as it has been in the past, or to try to take one state at a time in depth adding other facets to the collection of statistics.

Dr. Kornzweig mentioned that the National Eye Institute is more interested in research, but it should be done on a national level, however, they don't like statistics. He felt it is vital to keep blindness statistics under whatever Federal agency can do it. If any one can't or won't do it, some other should be appointed.

Recommendation:

It was recommended that a letter stating this idea go to Dr. Carl Kupfer and the Senate Committee on Aging with carbon copies to Dr. Flemming, Mr. Richardson, Senator Randolph, the Bureau of Census, the National Health Survey. Mr. Hanson seconded this and it was passed.

Dr. Kornzweig reiterated the need for AFB to become very much involved in the whole business of low vision clinics, as nothing seemed to be happening much at this point. Mr. Roberts responded by telling something of the history of low vision clinics in relation to the American Foundation for the Blind and the National Society for the Prevention of Blindness, and agreed that it needed to be done in partnership with the Federal government -- NSPB and AFB cooperating. Mr. Roberts also mentioned that the National Academy of Engineers was interested, not in research, but the delivery system which would be another way of attacking

the problem.

Dr. David told of the survey which was done a while back by the National Society for the Prevention of Blindness trying to find out how many low vision clinics there were and, at best, there were about 65. However, the range of their services and the time they were open, as well as the expertise in giving service covered a wide range. A new questionnaire is about to go out and it is hoped that there will be more information available later. It was also pointed out that the National Task Force on Independent Living was very much concerned with this item also, and Dr. Hoover was on that Task Force, as well as the one on Geriatric Blindness.

Recommendation:

It was felt important to involve Dr. Hoover immediately, and also to form a coalition committee of members of the Task Force on Independent Living, the Liaison Committee of the American Geriatric Society and AFB, and appropriate committee members from NSPB, as well as the HEW Advisory Committee, of which Mr. Crowley, the President of the Foundation, was a member. This recommendation was agreed upon wholeheartedly and the staff of AFB will start putting together this coalition committee.

Mrs. Kress, President, New York Infirmary, had the opportunity to answer questions about her report of the New York Infirmary *project. (See Appendix)

As the project is still in an initial planning stage, Mrs. Kress indicated that they would welcome suggestions on architectural structure within the facility and help in obtaining qualified staff. Miss Wurster offered the help of program specialists who could be helpful in delineating space needed for various types of rehabilitation programs, and also, continuing consultation, both through specialists and the regional consultants, as program developed. Mrs. Kress was most accepting of this idea and indicated that she would not only want to call on people after the project was started, but would be in touch with Miss Demby in the near future.

It certainly was exciting and most fortuitous that this project came to fruition about the time that the Task Force was meeting because it is another indication of the spread of interests which the Task Force has.

Mr. Rusk commented on the various concerns and recommendations of the Task Force and pointed out that it had proven to be a group which was a valuable vehicle in suggestions and outreach. AFB's staff have worked with Task Force members as individuals, in small groups and as a total group once a year. We are sincere about follow-up and this has produced requests for the largest budgets of the Department at any time.

He said that the Task Force was not just advisory, but involved in the now of program as seen in functional committees in regions. Our concerns are getting to state and local levels and we are beginning to do it; AFB has sort of been like a "marriage broker".

Mr. Rusk mentioned the meetings on attitudes which involved consumers and their feelings and what problems they are faced with.

This union is an essential one and it is hopeful that individuals on the Task Force will make themselves available on local, state and regional levels.

Dr. Morris recognized that there should be some termination of a "Task Force", and this one has gone on four years for excellent reasons. Mr. Fitch pointed out however, that this is the year of action following the White House Conference on Aging, and it is a critical time to put the action where the rhetoric has been. Mr. Meyer agreed with Mr. Fitch and wondered if maybe the Task Force should not stay in business.

Mr. McNamara asked what was the difference in keeping together as a group or not? Dr. Morris asked is there another way for AFB to get this kind of concentrated input. Mr. Roberts responded that there is a Service Advisory Committee which needs representation from those who are concerned with older people specifically.

He went on to say that perhaps the Task Force should not disband as such; why not keep the matter of the Task Force held open. Mrs. Russell responded by saying the Task Force should be kept even if it does not meet regularly. Miss Demby stated stated that as long as there is a staff member assigned to a specific topic such as this, there needs to be a body of persons outside the Foundation to whom the staff member can refer

and consult with.

Dr. Kornzweig summed up the discussion by saying that termination seems not to be the idea of most of the group. "We reject it because we want to stay in business." This brought great agreement informally. Dr. Levine suggested that perhaps the name should be changed. A Task Force means a limited time. Dr. Morris felt that this group could be a "bird dog from outside".

Recommendation:

Dr. Morris recommended an ongoing standing entity addressed to the topic of Aging Blindness which would be incorporated in AFB structure. This was approved.

Mr. Roberts agreed that the term represents temporary and that we needed to find another, and Mr. Rusk added that the Task Force had earned the right to "become something". AFB's staff will have to decide on structure and name as well as the charge.

After this discussion, there were several items mentioned briefly by Task Force members such as the concern of older people about the limited funds for programs for the aged which are in short supply. The need for services for older persons is ever present and sometimes the programs seem expendable; therefore, governmental and other groups may feel that, as money gets short, these programs can be left alone to struggle as best they can, so we need to keep ever vigilant.

Mr. Fitch mentioned that wheels are beginning to move for a National Conference on Religion and Aging, which was an outcome of a White House Conference Special Concerns Session. AFB needs to get an item on the agenda and again, he will talk with Dr. Flemming on the planning for this.

Mr. Jackson reiterated that viable conditions which can push for human services are important and not fragmented, even though Dr. Flemming mentioned that we go the categorical route also. Mr. Robinson pointed out that Dr. Flemming had also talked about the "Foundation Think" in relation to staff in the Federal government, starting projects and then dropping them. While there is danger in coalescing around categories forever, perhaps we need to do that, and at the same time, look at long-range.

Dr. Morris closed the meeting by mentioning that this is one of the few groups with which he meets where something actually gets done. He gave a well-deserved tribute to Miss Demby on being constantly available for follow-up on the recommendations

and also seeing that these were put into action. Miss Demby responded by saying that AFB and the staff were fortunate, too, to have such an interested and dedicated group, and that thanks were due to them also.

Dr. Morris and Mr. Meyer closed the meeting with thanks to all concerned and best wishes for a safe journey home.

IV. SUMMARY OF RECOMMENDATIONS FROM THE NATIONAL TASK FORCE ON GERIATRIC BLINDNESS

1. That the staff of the American Foundation for the Blind and the Task Force membership advise the Administration on Aging of the need to consider the concerns of elderly blind persons in all guidelines as developed by the Post Conference Board of the 1971 White House Conference on Aging. Provision of a general statement as well as consultation should be offered by the Foundation.

2. That the National Task Force on Geriatric Blindness (a) send a communication to Dr. Flemming directed toward the National Eye Institute stating the need for basic research in diabetic retinopathy; (b) explore with other national organizations interested in vascular and neurological diseases the possibility of a strong statement on the urgency of basic research on diabetes. This should be sent to Dr. Edward E. David, Jr., Science Advisor to the President and other key individuals with a copy to Elliot Richardson, Secretary, Department of Health, Education and Welfare.

3. That the Foundation cooperate with State Units on Aging to get blindness as a topic on programs; and to exploit that source of funding.

4. That AFB study the desirability of getting representation on various related federal Advisory Councils.

5. That consideration be given to the inclusion of blindness as content in various curricula in social work education, etc.

6. That the Foundation seek membership in the Consumer Federation of America.

7. That a letter be sent to Dr. Carl Kupfer and Senate Committee on Aging expressing the need for an agency to continue serving in the capacity of data collecting such as Model Reporting Area has served in the past.

8. That the Foundation initiate a coordinating committee that would include the various existing entities and key individuals working on some aspect of low vision aid clinics.

9. That the Foundation establish an ongoing structure addressed to the topic of aging and blindness.

APPENDIX

NATIONAL TASK FORCE ON GERIATRIC BLINDNESS

Preliminary Committee Meetings

Palmer House, Chicago

Thursday, May 25

4:00 p.m. - 6:00 p.m. Meeting	Committee on Standards/NAC Meets in hotel room of Chr. Mrs. Louise N. Mumm
7:30 p.m. - 9:30 p.m. Meeting	Liaison Committee AGS/AFB Meets in hotel room of Chr. A. L. Kornzweig, M.D.

Friday, May 26

9:00 a.m. - 11:30 a.m. On-Site Visit	Liaison Committee Low Vision Aid Clinic Chicago Lighthouse 1850 West Roosevelt Road Chicago, Illinois Chr. A. L. Kornzweig, M. D.
9:30 a.m. - 11:30 a.m. Meeting	Committee on Standards/NAC Meets in Private Dining Room #1 Chr. Mrs. Louise N. Mumm

AMERICAN FOUNDATION FOR THE BLIND, INC.

NATIONAL TASK FORCE ON GERIATRIC BLINDNESS

PALMER HOUSE, CHICAGO, ILL.

Friday, May 26, 1972

PROGRAM

12 Noon — Luncheon - Private Dining Room #4

Presiding:

Mr. Garson Meyer, Co-Chairman
National Task Force on Geriatric Blindness

Greetings and Introductions - Mr. Meyer

Welcome

Mr. Harold G. Roberts
Associate Director for Service
American Foundation for the Blind, Inc.

Keynote Address

Dr. Arthur S. Flemming, Chairman
White House Conference on Aging

Discussion

Closing Remarks - Mr. Garson Meyer

2:30 p.m.-5:30 p.m. **Business Meeting** - Private Dining Room #1

Presiding:

Mr. Garson Meyer

Reports to the Task Force
Program Development - Geriatric Blindness

Miss Dorothy Demby
Staff Associate, NTFOGB

Committee on Standards - NAC/AFB

Mr. Alexander Handel, Director
National Accreditation Council

Mrs. Louise N. Mumm, Chairman

Liaison Committee AGS/AFB

A. L. Kornzweig, M.D.,Chairman

AFB Regional Meetings on Geriatric Blindness

Mrs. Doris P. Sausser
Director, Community Services Division

New Aspects of AFB Program Development

Miss Marion V. Wurster, Director
Program Development Division

Discussion

Saturday, May 27, 1972

9:30 a.m.	Meeting - Private Dining Room #1
	Presiding:
	Robert Morris, D.S.W., Co-Chairman National Task Force on Geriatric Blindness
	Discussion Continued
	Recommendations to the American Foundation for the Blind, Inc.
	Response
	R. Roy Rusk, Director Program Planning Department
12:00 Noon	Adjournment

PARTICIPANTS AND GUESTS

Jessamine Cobb

Wilfred D. David,M.D.

Dorothy Demby

William C. Fitch

Arthur S. Flemming

Mrs. Rhoda Gellman

Alexander Handel

Howard H. Hanson

Lowell Iberg

Hobart C. Jackson

David Jeffreys

A.L.Kornzweig,M.D.

Mrs. A. L. Kornzweig

Mrs. Rush H. Kress

David L. Levine,Ph.D.

Martin J. McNamara

Peter G. Meek

Garson Meyer

John Guy Miller

Robert Morris, D.S.W.

Mrs. Robert Morris

Mrs. Louise N. Mumm

Ollie A. Randall

Harold G. Roberts

Robert Robinson

R. Roy Rusk

Mrs. A.M.G.Russell

Mrs. Doris P. Sausser

Mrs. Patricia S. Smith

Frederick C. Swartz, M.D.

Marion V. Wurster

Social Rehabilitation Training Project for the Geriatric Blind

Mrs. Virginia W. Kress, President, Board of Trustees,
New York Infirmary

"It was an unexpected honor to be invited to this meeting, and a high compliment indeed to be asked to speak to you.

First of all, I want to say that my personal exposure to the care of the blind is so very recent that I am still somewhat appalled by my temerity in consenting to speak to a group of outstanding professionals in the field. I am delighted, however, to have the opportunity to give you a brief outline of our hospital's program for social rehabilitation and training for the geriatric blind.

Since a unique feature of this project for the older blind person is that it will be operated in conjunction with our hospital, I think you might like to know something about the New York Infirmary. It is a 268-bed general voluntary hospital, and it is located on East Fifteenth Street overlooking Stuyvesant Square in New York City. It will interest you too, I think, to know that it was founded by Elizabeth Blackwell, the first woman to be granted a degree from a medical college in the United States.

Ever since Dr. Blackwell opened its doors for service in the Lower East Side in 1853, the pioneering and innovative spirit of this hospital has stimulated many "firsts" for the New York Infirmary. Perhaps the one which brought it closer than any other to the people of the neighborhood was the Out-Practice or Tenement House Service which brought medical and nursing care and relief measures into the home. This was the forerunner of medical social service. Today the New York Infirmary continues to play an important role in community medicine in serving as "back-up" hospital for an array of neighborhood groups and governmental agencies.

A whole new chapter in our record of service opened when we consolidated with the Society for the Relief of the Destitute Blind. The Society had been incorporated in 1869 to afford relief to the destitute blind by providing home and care for them, and this they did superbly for 100 years. By 1969, however, the number of blind persons in the home had dwindled to 50 -- with an average age of over 75.

After long deliberation the Trustees of the Society concluded that the home should be closed as soon as a place could be found to care for the remaining residents. Also, they felt they

should seek a wider field of service for utilizing their funds which had grown appreciably over the years. The program which has just been awarded a grant by HEW really had its beginnings, I think, in the exploratory talks and conferences which took place at that time between the representatives of the Society and the New York Infirmary.

Following the merger the blind residents moved into specially equipped apartments in a building across the street from the hospital which was owned by the Infirmary, and here they are receiving all necessary care which will, of course, be continued for their lifetime.

Immediately after the consolidation was effected, professional assistance was sought from the management consulting firm of Booz, Allen & Hamilton to help us determine how we could best serve the blind and the visually handicapped.

Subsequent research on the subject of blindness and rehabilitation and consultations with professionals in the field, including commissioners for the blind at both the State and Federal level, revealed that even though one-half of the blind people in the United States are over 65, present programs for the blind are primarily concerned with the educational needs of children and vocational rehabilitation for the young adult. While our program has vocational rehabilitational overtones, its main objective is the social rehabilitation of the older blind person.

In essence, the project involves the development and maintenance of a regional training facility in a residential setting for blind persons 55 and over, in order that these individuals after a couple of months' training, may regain their ability to function independently. As I stated earlier, a unique feature of the project is that it will be operated in conjunction with a hospital. The blind resident trainees will have immediate access to the Infirmary's medical services and staff -- an essential element for the older age group.

The geographical area in which service will be provided includes the states of New York, New Jersey, Pennsylvania and Connecticut.

Based upon Hurlin's statistics, the estimated blind population of these four States is 70,000. Again, accepting that 50% of the blind are 65 years of age or older, we believe the potential population to be served by our center is in excess of 35,000.

The four state agencies have indicated strong interest in our geriatric program and will cooperate to the extent their resources permit.

Under this program the New York Infirmary will erect a building on property which it owns adjacent to the main hospital in order to house the resident trainees. The facility will be suitably equipped and professionally staffed to provide rehabilitation services. The building will contain approximately 50 private apartments, and in addition to living quarters, it will have:

1 fully equipped apartment for home management instruction,
3 classrooms,
a large dining room,
auxiliary kitchen facilities,
a large recreation room.

1 room for physical conditioning which can accommodate a treadmill,
a stationery bicycle,
weight lifting equipment,
spinolator,
sauna bath, etc.

It is planned to have a solarium and there will be a private garden area behind the building. An examination room appropriately equipped will be provided, as well as offices for the professional and administrative staff.

A research program will be instituted and maintained to find the most effective means to accomplish successful social rehabilitation for these older blind people. A professional in the field of rehabilitation will be hired to design and supervise the program. An advisory board made up of leading experts will be appointed to advise the Infirmary's Committee on the Relief of the Blind regarding program content and administration.

An administrator with expertise in rehabilitation of the blind will be engaged and will be responsible for the operation of the facility and conduct of the project. Professionals in various disciplines will be hired on a programmed basis to provide a well-rounded service organization. A non-professional staff will be recruited to provide necessary supportive services.

Upon completion of the specialized facility, trainees will be selected to undergo an intensive resident training program. The selection criteria will be as follows:

Age 55 years or older
Residency in one of the four states I named -- that is, New York, New Jersey, Pennsylvania, Connecticut
Legally blind
Considered to have a reasonable expectation of benefiting from the project's services

Tuition will be requested from the states in which the trainees reside, to partially offset expenses not covered by the project's grant funds. No charge will be made to the trainees.

Clients will be thoroughly evaluated when they report to begin the training program. Thus, their initial medical, visual, psychological and social condition and needs will be determined. In the beginning, appropriate training will be provided over a 16-week period of residency. The elements of the program are:

Orientation and mobility
Home management
Communication
Activities of daily living
Leisure time activities

The 16-week period of training is thought to be necessary, initially, to enable the staff to refine the program. After some experience has been gained, subsequent training periods of 8 and 12 weeks will be conducted, and results obtained will then be compared to determine the optimum schedule.

The research will be directed toward measuring the progress made by the client in each of the major program elements I have just named. A rating scale will be developed by qualified professionals, which will utilize both subjective and objective factors. Measurements will be made during and at the conclusion of the program. Follow-up studies will be conducted to ascertain how effectively the client utilizes newly acqired skills after his return home.

Research will also be conducted to determine the optimum ratio of professionals to geriatric clients. Standards have been developed along these lines for younger blind clients. Our program objective in this phase of the work will be to identify how these standards should be modified for older clients, taking into account their receptivity and stamina.

A continuing study will be conducted aimed at determining the feasibility of utilizing sub-professional personnel. This effort is of major importance since there is a shortage of professionals trained to assist the blind, and this is expected to continue for some time. In addition, a substantial communication problem exists since the region proposed to be served has large populations of non-English speaking minority groups. The new program will be an excellent training ground for bi-lingual individuals who can, under the direction of the professionals, become proficient in the specialized elements of care for the blind. Each of the program functions will be studied to ascertain which tasks or portions of tasks can be delegated.

The objectives of this effort are to ascertain how best to deliver quality care at an optimum economic level, and how to alleviate the critical shortage of professionals which exists.

During the first year of operation, 20 trainees can be accommodated in each of the classes. As previously noted, the programs will be of 16 weeks duration; therefore, 60 clients can be trained the first year. The building, however, will be designed to enable the program to accommodate up to 50 students in a class in future years. The number of classes conducted per year, will be contingent upon the program research which I previously described.

To the best of our knowledge, the residential training program for the geriatric blind envisioned by the New York Infirmary is the first program where a specialized facility will be operated in conjunction with a general voluntary hospital. It will provide an opportunity to conduct highly meaningful research into the methods of providing non-vocationally oriented services to the geriatric blind.

While it is recognized that some of these services are already available to the visually handicapped, we believe this will be the first time that all of these elements are combined in a training and research program and utilized intensively in a residential setting, with full medical services immediately available.

This facility, if successful, will serve as a prototype for the establishment of similar facilities in other areas of the country.

Again, thank you for inviting me to attend your meeting."

Vision Screening of the Nursing Homes in South Dakota
A Project of Title III Older Americans Act 1969
Howard H. Hanson, State Director, Service to the Visually Impaired, Pierre, South Dakota

FACTS IN BRIEF

- 6,615 bed capacity in 150 licensed homes in 89 South Dakota communities.
- 58 communities have no optometrists or ophthalmological service.
- 16 counties have neither a Home nor a Vision Specialist. These counties contain the seven Indian reservations in South Dakota.
- Four homes did not participate in the Screening Program.
- Age ranged from 15 years to 106 years with 90% over sixty years and 59.1% over 80 years of age.
- There were 27% more female residents than males.
- 59% of all residents were eligible for Title XIX Medical Assistance.
- 9.9% of all residents had received eye care within the past twelve months.
- 125 residents were reported as blind plus an additional 676 were found to be legally blind at the screening.
- 1,622 residents were not screened or 27.5% because: 307 were too senile; 364 were unavailable; 252 refused; 575 were under treatment and 125 were known to be blind.
- 62% of the residents screened received public assistance; thus, making them eligible for Title XIX. 4,389 participated in the screening project of which 584 classified as no results due to language and other barriers.
- 676 were found to be legally blind at the screening. 602 were found to have less than 20/70 visual acuity.

- The incidence of blindness increased with the age of population. In the age group 30 to 40, 7.1% incidence; 50 to 59, 3.3%; 60-69, 7.8%; 70-79, 9.7%; 80-89, 19.7%; 90-99, 34.5% and 100 and over, 41%.

- Opacities were found in 58.2% of legally blind and 58.1% of the vision group 20/70 to 20/200 of those who had 20/70 visual acuity or better which were not surgically treated will probably result in total blindness. Of the 801 legally blind persons referred to Service to the Visually Impaired the agency had knowledge of 88 of these individuals.

- The tragedy revealed by this study was that 66% of all persons referred for additional eye examinations could have received this service under Title XIX if someone would have only made the effort. The complete report of the study should be available for distribution in June, 1972.